ND PLAN	T OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) Man 22	PLE CONSTRUCTION	OMB NO	MAPPROV 0. 0938-0:
		IDENTIFICATION NUMBER:	A. BUILDIN		(X3) DATE : COMPL	SURVEY
	<u></u>	445154	B. WING			EIEU
VAME OF	ROVIDER OR SUPPLIER		 ,		1111	07/2012
QUALIT	Y CARE HEALTH CER	ITER	[34	REET ADDRESS, CITY, STATE, ZIP COD 32 BADDOUR FARKWAY	E	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		EBANON, TN 37087		
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the second secon	Upon written author facility must hold, sa account for the pers deposited with the facility must deposited with the facility must deposited in excess of \$ account (or account the facility's operating all interest earned or account. (In pooled separate accounting The facility must mai unds that do not except cash fund. The facility must mai unds that do not except cash fund. The facility must established the facility must proceed to the established the facility must proceed the facility must established the fa	ization of a resident, the afeguard, manage, and onal funds of the resident acility, as specified in it of this section. Dosit any resident's personal so that is separate from any of graccounts, and that credits accounts, there must be a for each resident's personal sed \$50 in a non-interest rest-bearing account, or ablish and maintain a system of complete and separate to generally accepted of each resident's personal accounts are sident's personal accounts and maintain a system of complete and separate to generally accepted of each resident's personal accility on the resident's selude any commingling of solicity funds.	F 159	F159 Personal Funds 1. Effective November 8, 2 administrator established personal fund and a Week Fund Access policy (see att that will make personal fund available to all residents or weekends from 8:00AM to from the Business Office. 2. On November 7, 2012 the administrator notified all relationary and resident's POA by letter the accessibility to their perfunds on the weekend. A country that the Business Office winder the Business Office winder the Business Office winder 8, 2012. 3. All Business office staff we serviced on this access on Naccess on Naccess on Naccess on Naccess on these dates will not be a work until they have attendiness or reservices.	a resident rend Trust tached) nds n 4:00PM esidents er about rsonal topy of as posted ow on rere in- lov. 8, ervices	11/20
TI		A36h rogidant (L. L				

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for hursing homes, the findings stated above are disclosable 90 days following the date these documents are made available to the facility. If deliciencies are cited, an approved plan of correction is requisite to continued

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/09/2012 FORM APPROVED

NIII)	OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
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(X4) ID SUMMARY STATE PREFIX (EACH DEFICIENCY IN TAG REGULATORY OR LSC	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	RECTION HOULD BE PROPRIATE	COMPLETE DATE	
section 1611(a)(3)(B) amount in the account the resident's other not reaches the SSI resort resident may lose eligible. This REQUIREMENT by: Based on resident and and review of the Trust accounts, the facility faccess to personal funfor eligible residents. The findings included: Interview with resident at 3:10 p.m., and reside 2012, at 10:00 a.m. contour able to access person the weekends. Review of the facility's revealed ninety-four restactions.	aches \$200 less than the one person, specified in of the Act; and that, if the at, in addition to the value of enexempt resources, urce limit for one person, the publication of the person and the facility staff interviews at Fund Trial Balance ailed to provide weekend ands managed by the facility #72 on November 5, 2012, ent #152 on November 6, and funds at the facility Trust Fund Trial Balance sonal funds with personal fund the facility. Trust Fund Trial Balance sidents with personal fund the facility. Instrative Assistant, in the ember 7, 2012, at 8:50 lity does not routinely and funds for the	F 158		onitored rice nthly to a written relaterly enext enterly duled for nairman librief githe SSMENT survey hat properly ressed tor e to nal	11/21/12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 11/09/2012 FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 445154 NAME OF PROVIDER OR SUPPLIER 11/07/2012 STREET ADDRESS. CITY, STATE, ZIP GODE QUALITY CARE HEALTH CENTER 932 BADDOUR PARKWAY LEBANON, TN 37087 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX ΙD PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (XS) COMPLETION TAG DATE DEFICIENCY F 2721 483,20(b)(1) COMPREHENSIVE assistive device more appropriate to F 272 \$\$=D! **ASSESSMENTS** the resident. The facility must conduct initially and periodically 2. On November 8, 9,& 12, 2012 all a comprehensive, accurate, standardized residents utilizing assistive devices reproducible assessment of each resident's were assessed by the MD\$ functional capacity. Coordinator and physical therapy to A facility must make a comprehensive ensure appropriateness of their assessment of a resident's needs, using the assistive device. All residents were resident assessment instrument (RAI) specified found to have appropriate assistive by the State. The assessment must include at device (see attached assessment least the following: Identification and demographic information; 3. Beginning November 21, 2012 Customary routine; Cognitive patterns; residents with new orders for Communication; assistive devices will be assessed Vîsian; and evaluated within 72 hours for Mood and behavior patterns; appropriateness by the therapy staff Psychosocial well-being: Physical functioning and structural problems; and recorded in their progress Continence: notes. This will be monitored weekly Discase diagnosis and health conditions; by MDS Coordinator for a period of 6 Dental and nutritional status: months or longer until 100% Skin conditions: compliance is achieved. (see Activity pursuit: attached monitoring tool) Medications: Special treatments and procedures; 4. Beginning November 21, 2012, Discharge potential; the MDS coordinator will report the Documentation of summary information regarding outcomes of the monitoring of the the additional assessment performed on the care timeliness and appropriateness of areas triggered by the completion of the Minimum the assistive devices to the quarterly Data Set (MDS): and Documentation of participation in assessment. QAPI committee beginning December 13, 2012 and continue for the next 2 quarters. The Chairman of the QA/PI Committee will report

to the Governing Body following the

quarterly QAPI meeting.

STATEMEN IND PLAN	IT OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION	OMB NO	D: 11/09/20 MAPPROV <u>D. 0938-03</u> SURVEY
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(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES		EBANON, TN 37087		
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F 272	Continued From pag	Te 3	·			 -
			F 272	Attachments:		
- 1	This DECLUDE:		[3) List of Residents assesse	d by MDS	}
}	ph:	T is not met as evidenced		Coordinator and Therapy s	taff for	ľ
	Based on medical reco	ecord review observer	j	appropriate assistive device	Δ.	[
j			İ	4) Monitoring tool for repo	rting to	{
- 1	THE PERMET	T 14473791 E 1	ļ	QAPI committee on the time	eliness	
	to improve/maintain functional abilities of forty-four residents reviewed. The findings included:			and evaluation of assistive	davice.	[
		l:	[
	Resident #273 was a June 13, 2012 with a	dmitted to the facility on	ļ			
] (Obesity, Urinary incom Mental Retardation, a	lagitoses including Morbid				
ņ	Medical record review Pata Set (MDS) dated	of the quarterly Minimum	}			
l r	eVealed the resident	September /, 2012,	}		-	
			`		ſ	
			j			
İs	eptember quarterly N	the several distribution of the				
					ļ	
	eu mobility, and was it transfers.	dependent on two persons	}			
M	edical record review	of the Occupation -	Ì Ì		1	
1	TOPY INCOMINENT FOR	COUMANNAL II	}		1	
					İ	
		ovided in toileting/clothing s by the therapy	ļ		1	
de	partment to the resid	ent and facility staff.				
Mo	edical record review (of the interdisciplinary	Ì		}	
	am note revealed the optember 12, 2012, w	racidosia! L.c 1	1			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 11/09/2012 FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 445154 NAME OF PROVIDER OR SUPPLIER 11/07/2012 STREET ADDRESS, CITY, STATE, ZIP CODE QUALITY CARE HEALTH CENTER 932 BADDOUR PARKWAY LEBANON, TN 37087 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREF!X (X5) COMPLETION TAG DATE **DEFICIENCY** F 272 Continued From page 4 F 272 Observation on November 7, 2012, at 9:15 a.m., revealed Certified Nurse Technician (CNT) #1, transferred resident #273 to the bedside commode. Continued observation revealed the resident's feet did not touch the floor, and the resident's legs were dangling. Continued observation revealed CNT #1 instructed resident #273 to move back on the toilet seat to keep the resident off the edge. Continued observation revealed the resident used the rail/armrest on the side of the bedside commode to reposition self. Observation and interview with the Unit Manager, Licensed Practical Nurse #1, on November 7, 2012, at 9:20 a.m., In the resident's room, confirmed the resident's legs were dangling, and the feet should be touching the floor. Interview with the Rehabilitation Director on November 7, 2012, at 9:44 a.m., at the nurse's station confirmed the resident had not been assessed for the appropriate height of the bedside commode chair that would allow the resident's feet to touch the floor, F 279 483.20(d), 483.20(k)(1) DEVELOP COMPRÉHENSIVE CARE PLANS F 279 SS=n F279 DEVELOP COMPREHENSIVE 11/24/12 A facility must use the results of the assessment CARE PLANS to develop, review and revise the resident's 1. On November 8, 2012, upon comprehensive plan of care. becoming aware of no care plan for resident # 22 concerning vision The facility must develop a comprehensive care difficulties, the MDS Coordinator plan for each resident that includes measurable revised the comprehensive plan of objectives and timetables to meet a resident's care to address vision difficulties. medical, nursing, and mental and psychosocial 2. Beginning November 10 and needs that are identified in the comprehensive

assessment.

continuing through November 21, 2012 all CAAS were reviewed by the

	TOF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	JLTIPLE CONSTRUCTION DING	OMB NO	D: 11/09/20 M APPROVI <u>D. 0938-03</u> SURVEY LETED
WARE OF S		445154	B. WING	3 <u></u>	}	
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i 	The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and		F 27	MDS burging 55	arone	
	be required under § due to the resident's §483.10, including to under §483.10(b)(4)	483.25 but are not provided exercise of rights under ne right to refuse treatment		3. On November 13, 2012 conducted an in-service wi staff (RNs & LPNs) concernitriggered problems on the i	th MDS ng CAAS	
t c fe	Based on medical re he facility falled to do if care for vision for a ourty-four residents	<u>!</u>		must be care planned indivand the MDS staff must concars to the comprehensive care to ensure no problems missed. Beginning Novemb 2012, the DON and or ADON	dually opare the plan of are er 24	
- 1	he findings included	<u> </u>		monitor all CAAs and Care P	lans	
G	Resident #228 was admitted to the facility on Ma 26, 2010, with diagnoses including Convulsions, Dementia, Senile Depression, Dysphagia, Acute Conjunctivitis, Edema, Generalized Anxiety and Generalized Pain.		1 d	completed during a 6 week to ensure no identified prob missed. DON and/or ADON on continue monitoring 10% on monthly basis for 3 months	lems are vill a	
vi: re bt	sion was marked as vealed the resident of it not regular print in			substantial compliance has be achieved. 4. DON will report outcomes Care Plan to the QAPI comm quarterly for two quarters. T	of the littee	
1 4415	45 Y. ZVIZ. HINI IINI	of the care plan created lated August 15, 2012, eed entered for vision.		quarterly QAPI Committee m is scheduled for December 1: The Chairman of the QA/PI Committee will report to the	eetina (
Int	erview with MDS Co	ordinator #1, on November		Governing Body following the quarterly QAPI meeting,	}	

STATEMEN	AT OF DEFICIONORS	AND HUMAN SERVICES			FOR	D: 11/09/2011 MAPPROVE
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION ING	(X3) DATE	D. 0938-039 SURVEY LETED
NAME OF	SPOMETE AT THE	445154	B. WING			
	PROVIDER OR SUPPLIER		Si	REET ADDRESS, CITY, STATE, ZIP CODE	11/	07/2012
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PREFIX TAG		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR		(XS) COMPLETION DATE
F 282 SS=D	plan. Further intervibeen made on the C with o/p (care plan), develop a plan of care 483.20(k)(3)(ii) SER' PERSONS/PER CART The services provided by accordance with each care. This REQUIREMENT by: Based on medical related to the applicate interview, the fact appropriate measures related to the applicate indicated on the care (#266) of three reside alcers from forty-four interview. The findings included: Resident #266 was addingled; with diagnose 2012, with diagnose	m., in the MDS office is listed on the annual MDS as not carried over to the care ew revealed a notation had AT worksheet "will proceed but the facility had failed to re for vision. VICES BY QUALIFIED RE PLAN in the facility qualified persons in the resident's written plan of the is not met as evidenced cord review, observation illity failed to ensure is to prevent skin breakdown ion of arm sleeves, as plan, for one resident nots reviewed for pressure residents reviewed.	F 282	Attachments: 5) Monitoring spreadsheet for reporting to QAPI committee Care plans for identified problem on the MDS assessments. F282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 1. On November 7, 2012, upon notified by survey team that the facility failed to ensure appropriate measures were followed for reflecting arm sleeves, the M Coordinator reviewed the comprehensive plan of care an placed the Posey sleeves on the resident immediately. 2. Beginning on November 10a continuing through November 2012, the DON, ADON and Word Care Staff reviewed all resident with wound care plans to deterif appropriate measures were in place to prevent skin breakdow	r on lems lems lems lems lems lems lems lems	11/21/12
V E N D	Veakness, Hypertens Disorder with Psychosi Medical record review Data Set (MDS) dated	ascular Accident, Muscle lon, Senilo Depressive is, and Esophageal Reflux. of the quarterly Minimum		All residents were found to have appropriate care plans. 3. Beginning 11/7/12 and continuing 11/21/12, the DON and	e Nuing	

FAX NO. P. 09/75 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 11/09/2012 STATEMENT OF DEFICIENCIES FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AND PLAN OF CORRECTION OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED 445154 B. WING NAME OF PROVIDER OR SUPPLIER 11/07/2012 STREET ADDRESS, CITY, STATE, ZIP CODE QUALITY CARE HEALTH CENTER 932 BADDOUR PARKWAY SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL LEBANON, TN 37087 (X4) ID PRÉFIX PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 282 | Continued From page 7 ADON performed in-services with all with Activities of Daily Living. F 282 staff (RNs, LPN, & CNTs) concerning Medical record review of the Care Plan, dated following interventions put in the October 18, 2012, revealed "...at risk for skin care plan i.e. arm sleeves to prevent breakdown related to present skin skin breakdown. impairment...h/o (history of) resolved/healed Any staff not attending in-services pressure ulcers...arm sleeves to bilateral arms at on these dates will not be allowed to all times except bathing..." work until they have attended the Observation on November 6, 2012, at 4:25 p.m., in-services. in the resident's room, revealed the resident lying The Wound Care staff will monitor on the bed with no arm sleeves in place. weekly all residents who have Observation on November 7, 2012, at 7:40 a.m., interventions such as arm sleeves, in the resident's room, revealed the resident lying padded w/c arms, or any special on the bed with no arm sleeves in place. treatment to prevent skin breakdown and provide a list of Observation and interview on November 7, 2012, residents monitored each week to at 7:45 a.m., with Licensed Practical Nurse (LPN) DON and/or ADON and record any #1, in the resident's room, confirmed the arm sleeves were not in place and the care plan was variances noted each week not followed. 4. The DON will provide the F 323 483.25(h) FREE OF ACCIDENT SS=D HAZARDS/SUPERVISION/DEVICES outcomes of the monitoring to the F 323 QA/Pi Committee for the next two The facility must ensure that the resident quarters. The next quarterly QAP! environment remains as free of accident hazards Committee meeting is scheduled for as is possible; and each resident receives December 13, 2012. The Chairman adequate supervision and assistance devices to of the QA/PI Committee will report prevent accidents. to the Governing Body-following the quarterly QAPI meeting. Attachment: This REQUIREMENT is not met as evidenced 6) Monitoring tool to be used to

Based on medical record review, observation,

and interview, the facility failed to ensure the safe

by:

record weekly reviews of

interventions on care plan is carried

DEPAR CENTE	TMENT OF HEALTH	AND HUMAN SERVICES			PRINTE	D: 11/09/201:
I GIALEMEN	f of Deficiencies Of Correction	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION NG	FORM APPROV OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED	
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QUALIT	y care health cen			REET ADDRESS, CITY, STATE, ZIP CODE 932 BADDOUR PARKWAY LEBANON, TN 37087	_1 37/	<u>07/2012</u>
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	residents reviewed. The findings include Resident #273 was June 13, 2012, with Obesity, Urinary Incomental Retardation, Medical record review Data Set (MDS) date revealed the resident of the questions on the Status (BIMS) scorin possible score, Contimus (BIMS) scorin possible score, Contimus dependent on the Medical record review assistance of two pewas dependent on the Medical record review Therapy Treatment E13, 2012, revealed Sinstruction had been management technique facility staff. Medical record review the management facility staff. Medical record review the management facility staff. Medical record review the management facility staff. Deservation on November 12, 2012, Deservation on November 12, 2012, Deservation on November 12, 2012, Deservation on November 12, 2012, Deservation on November 13, 2012, Deservation on November 14, 2012, Deservation on November 15, 2012, Deservation on November 16, 2015, Deservation on November 17, 2015, Deservation on November 18, 2016, Deservation on November 18, 20	device in regard to chair ant (#273) of forty-four addited to the facility on diagnoses including Morbid ontinence, Schizophrenia, and Encephalopathy. w of the quarterly Minimum and September 7, 2012, the was unable to answer any the Brief Interview for Mental of 9 with 15 being the highest inued review of the quarterly sident required extensive resons for bed mobility, and to persons for transfers. w of the Occupational incounter Note dated July all Care Management provided in toileting/clothing uses to the resident and to of the interdisciplinary the resident's weight on was 383 pounds. mber 7, 2012, at 9:15 a.m., ree Technician (CNT) #1	F 323	F323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DE 1. On November 7, 2012, up notified by survey team that facility falled to ensure the second and assistive device for resection to the second with the appropriate height that allowers feet to touch the second and second for appropriate to November 8, 9 and 12 the MDS Coordinator and Difference and safe use 3. Beginning on November 2, 8, 2012, in-second second s	t the safe use sident # ght a wed floor. 2, 2012 irector of a priate 21, 2012 rvices /ADON aff (RNs, and dents.	11/26/12

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-			F323	F323	·	
				work until they have atten in-services.		
ţ				Beginning November 21, 2 new residents admitted wi	012, all	
į			}	orders for assistive devices	70 have	l
ĺ				Commode) will be assessed	i beasige I hv	; ;
j	•			Therapy staff to determine		
1			1	suitability according to resi	dent's	
İ				physical capabilities/limitat	ions. This	
Į.			}	assessment will be recorde	d in their 🗼	
į			ļ (progress notes. Beginning	1	
i				December 1, 2012, the MD	S	
				Coordinator will monitor m	onthly	
İ				the assessments and docum	nentation	
{				completed by Therapy staff report the outcomes to the	and r	
}		İ		Committee.	QAPI	
}		ļ	1	4. The MDS Coordinator wil	l renort	
j			İ	monitoring outcomes to the	OA/PI	
			1	Committee at the next two	quarterly	
Ì				meetings. The next quarter	IV OAPI	
			į	Committee meeting is sched	luled for	
ļ			İ	December 13, 2012. The Ch	airman	
i		}	1	of the QA/PI Committee will	report	
				to the Governing Body follow quarterly QAPI.	Wing the	
				Attachment:		
Í		j	-	4) Monitoring tool for report	ing to	
			J	QAPI committee on the time	liness	
{		Y	ſ	and evaluation of assistive di		

my deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 30 days also date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction are disclosable 14 regram participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/09/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CONSTRUCTION	OMB N	OMB NO. 0938-0	
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(X4) ID PREFIX (E	SUMMARY STA	TEMENT OF DEFICIENCIES	1	LEBANON, TN 37087			
TAG RE		MEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	11010 4	COMPLET DATE	
Inches reveal move off the resider bedsid Observations and the floor common the floor common station at the floor consider authorities (2) Store under sation at the floor consider authorities (2) Store under sation authoritie	pack on the to edge. Continut used the rate commode to estion and interest of Practical Nat 9:20 a.m., continued the confirmed the when properties and prepare, distributed from the confirmed the confirmed the confirmed the confirmed the confirmed the confirmed the confirmed the confirmed from the confirmed satisfactors; and confirmed conditions are conditionally conditions. Culrements of the confirments of th	ar. Continued observation structed resident #273 to oblet seat to keep the resident nued observation revealed the ill/amrest on the side of the oreposition self. Berview with the Unit Manager, furse #1, on November 7, confirmed the resident's legs and the feet should touch the chabilitation Director on at 9:44 a.m., at the nurse's resident's feet should touch ray seated on the bedside of the bedside of the bedside of the sources approved or fy by Federal, State or local stribute and serve food ons is not met as evidenced and interview, the facility cedars and Quality, failed to a sanitary manner.	F 37	23	s Dietary sent on ter floor tment, y he ted all	12/10/13	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICE

PRINTED: 11/09/2012 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA				FORM OMB NO	M APPROVED). 0938-0391	
NOD PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE (SURVEY
4133 100		445154	8. WING			
	PROVIDER OR SUPPLIER				11/6	07/2012
QUALIT	TY CARE HEALTH CEN	TER	ST	REET ADDRESS, CITY, STATE, ≥IP CODE 932 BADDOUR PARKWAY		· · · · · · · · · · · · · · · · · · ·
(X4) ID				LEBANON, TN 37087		
PREFIX		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	10	· · · · · · · · · · · · · · · · · · ·		_
TAG		TO IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)		COMPLETION DATE
F 371	Continued From page	ne 10	-	all the dietary staff of Ceda		
	The findings include	ay. Ae in	F 371	Quality Dietary Departmen	te anu	į
	1		<u> </u>	concerning proper cleaning	rof <i>c</i> ailine	}
ļ	Observation on Nov	ember 5, 2012, beginning at	į	vents, floors and floor space	e Also	ļ
	I Continue Abiti title 1:	4131107 RODINESS-11 D.C. 1977		included in the in-services	e. Also	
	(RD) present, reveal	led the following:		use of a weekly sanitation of	has the	1
	Cedars dietary dena	rlment beginning at 9:35		by Dietary managers.	THECKING	}
	{ →			, , , , , , , , , , , , , , , , , , ,		1
j	1.) The walk-in refrig	gerator had black debris		Į.		ĺ .
}	i ''waamuu nomi me rei			Ann -1-25	İ	
j		s of tomatoes, cucumbers, d in the refrigeration unit.		Any staff not attending in-s	ervices	
Ţ		TETATOR BOOK LAA LAARI	Í	on these dates will not be a	llowed to	
j			İ	work until they have attend in-services	led the	
[ਾਮ ਮਾਦਿ Dack side ਅ	the inferior by Law	1		ļ	
[skillet had a build-up	of greasy debris.	ł	3. For the next 12 weeks be	ginning	İ
İ	Quality dietary depart	ment beginning at 10:36		Nov. 13, 2012, and then mo	onthly for	
1		i Certified Dietary Manger	Ì	the next four months, the D	ietary	J
			İ	Manager will inspect the fac	ility	ł
	1.) The Walk-in freez	er had a storage rack on the	}	dictary refrigerators on a da	illy basis	1
	closest to the door.	surface on the support pole	1	for debris and record the ins	spection	1
[]	The walk-in freeze	or floor by the door Jamb	}	as a part of their temperatu The Dietary Manager will pr	re log.	1
, ,	· · · · · · · · · · · · · · · · · · ·	/	İ	those logs as well as the wee	ovide	}
7 '	Y-7 (110 W2)K-)D 178677	or and the court to		sanitation checklist to the Re	≅KIY	
, ,	remgerator had a buil the condenser units.	d-up of Ice on the exterior of	Ì	Dietitian on a weekly basis for	Bizzelog	
	4.) The can opener o		ļ	next 12 weeks, then monthly	orthe	{
	build-up of black stick	y debris in the blade slot		next four months.	y for the	ı
	- L - G ,		i	4. The Registered Dietitian w	ili	
] 5	7.) The exterior top of	the convection oven had	†	report the monitoring outcom	mae of	
	rii 4008 liillia liiki in Ari	ST DEGCARE		the daily inspections and con	uniation nes UI	}
d	lark colored debris pr	k splash had a build-up of	ļ	of the sanitation checklist to	tha	ſ
17	'-) ∃Ne exterior surfac	'A and the beek]	QA/PI at the next 2 quarterly	-11C	1
l	THE THE PERSON WAS A PERSON WAS	liet had a build-up of	1	meetings. The next quarter	v OAbi	1
9	reasy debris.			Committee meeting is schedu	tlad	
i // CMS_20027	(02-99) Previous Versions Obs		_	December 13, 2012. The Cha	irman	
	verson Frevious Versions Oke	oleje				i

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/09/2012 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED B. WING 445154 NAME OF PROVIDER OR SUPPLIER 11/07/2012 STREET ADDRESS, CITY, STATE, ZIP CODE QUALITY CARE HEALTH CENTER 932 BADDOUR PARKWAY LEBANON, TN 37087 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL 1D PREFIX (XS) COMPLETION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAĞ CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 371 | Continued From page 11 of the QA/PI Committee will report F 371 to the Governing Body following the Interview on November 5, 2012, at the times of quarterly QAPI meeting. the observations, in the respective dietary departments, with the RD and/or CDM present Attachment: during the observations, confirmed the following: 7) Temperature Log Cedars dietary department beginning at 9:35 8) Weekly Sanitation Checklist The walk-in refrigerator had black debris hanging from the ceiling, in front of the condenser unit, 1. Upon being notified of the ice with exposed raw vegetables and fresh eggs build-up on the exterior of the stored in the unit. The walk-in refrigerator had a condenser unit of the walk-in build-up of ice on the exterior of the condenser refrigerator in the Cedars Dietary unit. The back side of the interior lid of the tilt Department; and ice buildup on the skillet had a build-up of greasy debris. condenser unit of both the walk-in Quality dietary department beginning at 10:36 refrigerator and walk-in freezer of a.m.: the Quality Dietary Department, the The walk-in freezer storage rack, on the left side, facility Maintenance Director had a rusted surface on the support pole and the contacted a refrigerator repairman floor jamb area had an accumulation of debris present. The walk-in freezer and the walk-in to have the refrigeration units refrigerator exterior of the condenser units had a inspected, serviced and/ or repaired build-up of ice. The cook side can opener had a by 12/10/12. (See Purchase Order) build-up of black sticky debris. The exterior top While the refrigeration units are surface of the convection oven had an

greasy debris.

accumulation of dust. The range top back splash

had a build-up of dark colored debris present. The exterior surface and the back side of the

Interior lid of the tilt skillet had a build-up of

being inspected, services and/or

repaired to eliminate icing, food

refrigeration units will be stored in

refrigeration trailers. (see Purchase Order). This is scheduled to be

The remaining refrigeration unit in Cedars Dietary was inspected for

items currently stored in the

completed on 12/10/12

CENTER	VIENT OF HEALT! S FOR MEDICAR OF DEFICIENCIES	H AND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: 11/09/2 FORM APPROV OMB NO. 0938-03	
AND PLAN OF	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILL	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
	·	445154	B. WING		}	
NAME OF PRI	OVIDER OR SUPPLIER			TDEFT ADDRESS AND DELLE	11/6	07/2012
	CARE HEALTH CE			TREET ADDRESS, CITY, STATE, ZIP CODE 932 BADDOUR PARKWAY LEBANON, TN 37087		
(X4) ID PREFIX TAG	CENCH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE	OUTOBE	(X5) COMPLETIO DATE
			F371	F371		
				ice buildup and no buildup v found.	vas	
				3.Begining on 12/10/12, and		
į				next 12 weeks, and then mo	nthly for	İ
į				the next four months, the D	ietary	Ì
i			ļ	Manager will inspect the fac		}
			į	refrigerators on a daily basis		
			}	build-up and record the insp		ì
j				as a part of their temperature.		,
ļ			}	The Dietary Manager will protection those logs to the Registered	ovide	1
				Dietitian on a weekly basis for	ne tha	
ļ			† 1	next 12 weeks, then monthly		1
1			İ	next four months.	y ioi tile	1
1				4. The Registered Dietitian w	/ill	
			1	report monitoring outcomes		1
Ì				concerning the inspections of	of the	1
}			İ	refrigerator temperatures ar	nd ice	
ļ			ŀ	buildup to the QA/ at the ne		
]	quarterly meetings. The ne		į
-				quarterly QAPI Committee n	neeting	
İ			ļ	is scheduled for December 1	3, 2012,	}
			İ	The Chairman of the QA/PI		}
- !			ļ	Committee will report to the Governing Body following th	-	
[quarterly QAPI meeting.	Ę	
			<u>.</u>	Attachment:		
}			ŀ	9) Purchas order refrigerator	repair	
				10) Purchase order trailer re	ntal	
ļ			Ï	7) Temperature Log/Inspecti	on log	
	PECTORE OF ADA	TOTAL TOTAL		for inspection of ice buildup.		
J. J. J. WILL DI	TO LOUG OU LUCIVIO	ER/SUPPLIER REPRESENTATIVE'S SIGN	VATURE	TITLE		CYR) DATE

Iny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 lays following the date these documents are made available to the facility. If deficiencies are clied, an approved plan of correction is requisite to continued

(XB) DATE

ATEMPOT.	S FOR MEDICARE OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE	OMB NO. 0938-0: (X3) DATE SURVEY	
			l l	BUILDING		LETED	
AME OF PE	OVIDER OR SUPPLIER	445154	B. WING_		مم أ	Marine 4-	
	CARE HEALTH CEN	VIER	j e	REET ADDRESS, CITY, STATE, ZIP CODE 132 BADDOUR PARKWAY	<u>1 11/</u>	<u> </u>	
(X4) ID PREFIX	SUMMARY STA	ATEMENT OF DEFICIENCIES	1	EBANON, TN 37087			
TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI GROSS-REFERENCED TO THE AF DEFICIENCY)	UC410 D Sec	COMPLET DATE	
,			F371	F371	····································	-	
				1. On November 5, 2012, unotified of debris on the tilt the Cedars Dietary Department the debris on the can open convection oven, range top splash, and tilt skillet in the Dietary Department, the distaff immediately cleaned the equipment. 2. The remaining food prepequipment in both the Cedar Quality Dietary Department checked that day for cleaning found to be free of debris. 11/5/12, Dietary employees Cedars and Quality Dietary Department were inservice proper cleaning of food prepequipment. Any staff not attending insee on these dates will not be all work until they have attended inservices	t skillet in nent; and er, back Quality stary he aration ars and were ness and On for don paration arvices lowed to		
		VSUPPLIER REPRESENTATIVE'S SIGNA	ĺ				

Any deliciency statement ending with an asteriak (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the potients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 80 days ollowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 groups participation.

DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES			PRINTED:	
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				APPROVED
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		445154	B. WING		}	
NAME OF	PROVIDER OR SUPPLIER				11/07	/2012
QUALIT	Y CARE HEALTH CEN	TER	ļ	TREET ADDRESS, CITY, STATE, ZIP CODE 932 BADDOUR PARKWAY LEBANON, TN 37087		
(X4) ID PREFIX TAG	TOTAL TENCH	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	the security	(X5) COMPLETION DATE
! ,			F371	F371		
				3. Dietary manager will monidally cleaning of food preparequipment on a daily basis at record those checks on a week sanitation checklist to be proto the facility RD. 4. The RD will report the monoutcomes concerning the procleaning of food preparation equipment to the QA/PI Commetting is scheduled for Decord 13, 2012. The Chairman of the QA/PI Committee will report Governing Body following the quarterly QAPI meeting. Attachments: 8) Weekly sanitation checklist	ation nd ekly vided nitoring oper mittee ngs. mittee ember le to the	
SS⇔D	OPERATING CONE	ITIAL EQUIPMENT, SAFE HITION RISUPPLIER REPRESENTATIVES SIGN	F 456	F456 ESSENTIAL EQUIPMENT, OPERATING CONDITIONS 1. On 11/8/12 the facility maintenance manager ordere replacement door (see attach Purchase Order) for the Quali Dietary walk-in refrigerator. I door is projected to be deliver 11/29/12. While the food iter stored in the refrigeration uni	ed a ed ty The red on	2/10/12
	== ALL LIMAINE	HOOF FLIER REPRESENTATIVE'S SIGN	ATURE	TITLE	DXI	B) DATE

Vry deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ather safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days oliowing the date these documents are made available to the facility. If deficiencies are alled, an approved plan of correction is requisite to continued magnature.

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445154		(X1) PROVIDER/SUPPLIED/CLA	(X2) MULTIPLE CONSTRUCTION A BUILDING		FORM APPROV OMB NO. 0938-0: (X8) DATE SURVEY COMPLETED		
		B. WING		}			
QUALITY CARE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 932 BADDOUR PARKWAY		11/	11/07/2012	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (XS) COMPLE DATE			
			the Cedars and Quality Dietary Department are stored in the refrigerated trailers from 12/3/12 till 12/10/12, the facility maintenance department will install the new door and replace the floor on the Quality Dietary Departments refrigerator. 2. The remaining refrigeration equipment of both Cedars and Quality Dietary Departments were checked by facility maintenance personnel and found to be serviceable. 3. The Dietary Manager will inspect all refrigeration equipment weakly for needed service and report the results of that Inspection monthly to the RD. 4. The RD will report to the QA/Pi Committee on the results of this inspection at the next 2 quarterly meetings. The next quarterly QAPI Committee meeting is scheduled for December 13, 2012. The Chairman of the QA/Pi Committee will report to the Governing Body following the quarterly QAPI meeting. Attachment:				